Interview with Alan Wallace
Date: November 9, 1995
Interviewer: Jan Herman

Herman: Where are you from originally?

Wallace: Originally I'm from Ohio, a little town down on the Ohio River called Middleport.

Herman: When did you enlist?

Wallace: August 2, 1965.

Herman: You could probably tell me what hour, too, if I asked it.

Wallace: Yeah, I suppose.

Herman: How'd you decide you wanted to be a corpsman, or you just decided you wanted to be in the Navy?

Wallace: Well, I decided--I thought I'd like to be a sports trainer, like what they do now in sports medicine. I always thought that would be interesting, and the Navy offered a program, and they also offered a Physical Therapy School, and I thought that would be the way to go for me at that time. As it turned out, I did get to go to Hospital School and I was offered the Physical Therapy School, which at that time one of them at Bethesda. After working a while as a hospital corpsman on the wards, I decided I didn't want to do that anymore.

I had already had, by that time, extended my enlistment nine months so I could attend the Physical Therapy School, no getting out of that. I had my orders changed, apparently it was a miracle, and I went to Operating Room Technician School, which was also at Bethesda.

Herman: What was that like, Operating Technician School?

Wallace: That was about, at the time, it was six months, six months of schooling, a lot of classroom. I think the intimidating thing about it when you first start is when they show you the operating rooms and they show you the instruments that are used, there are so many instruments, and I think many people would see this and think, "Man, I'll never memorize all these things." To me, and maybe everyone would say the same thing, the instruments were very easy to memorize, because you were working with them every day.

When we would take the tests for these things, they'd hold the instrument up and you would tell them what it was, you had to be able to spell it. So at least by the time you got through the school, you knew the instruments very well and if you'd go to another duty station they might call a particular instrument by a little bit different name, but basically they were same and they were always used for the same thing. Like in construction, a shovel is used to move something like dirt, a hammer is used to pound something, and a Hamas statue is to crush a piece of bleeding tissue, stop it from bleeding.

Herman: So after you passed your exam, where did you go from there?

Wallace: My next duty station was the Navy Hospital at Portsmouth, Virginia. I left Bethesda the very last day of April 1967. I had a ride with some friends that were going down that weekend, took me right to the Navy Hospital, and I was there from April 'til about the 15th of November. I did work in the operating room all that time while I was at Portsmouth, Virginia.

I left the Navy Hospital at Portsmouth about the middle of November and then my next big duty station was to Vietnam.

Herman: Had you volunteered for that or was that something you just--

Wallace: Honestly, I wanted to get away from the nurses. I just thought it would be more a challenge maybe.

Herman: What was the relationship between the corpsman and the nurses at the hospital? Was it a little tense? They were giving you guys orders and you resented it?

Wallace: I don't think anyone really resented it too much. I don't think it would be--for me it wasn't because the nurses were females, or they weren't much older than we were. I mean, you know, you could be an E-3--at the time I was an E-4, and you can have somebody that's a year older than you or maybe your age and be an E-4 and maybe he's in charge of the unit or something like that or he's in charge of your duty section and he's running things. So I don't think age was the thing. I don't think I resented that a female was telling me what to do, I don't think so. I just thought maybe it would be more of a macho thing maybe, you know, to be away from the stateside hospital style and see what that would be like.

Herman: So you got your orders, and how did you get there?

Wallace: I had money and everything, so I took a plane from Columbus, Ohio, to Los Angeles, and I was supposed to check in at Norton Air Force Base in San Bernardino. It looks like it's about eighty miles east of Los Angeles out in the desert. So the plane went from Columbus, Ohio, to Chicago and then from Chicago it was supposed to be a non-stop to Los Angeles. Because of the weather or the smog or whatever, we couldn't land in L.A., so we had to land in a little place called Ontario, California. When they said Ontario, I figured we were up in Canada. I didn't know too many other Ontarios.

So this actually worked out better, because Ontario is, I would say, within ten miles of Norton Air Force Base. So we get there about two o'clock in the morning, and I was telling this guy that I was with, who'd been on the plane with me, there a boy from my hometown that lived in California somewhere and he worked for an airplane company. So about 6:30 the next morning, we had to wait around in the airport there and a bus would come by and pick up the servicemen and take them from the airport to Norton Air Force Base, and there are a couple other military bases around there. So we didn't have to pay for the transportation from Ontario Airport to Norton.

But while we were there waiting, here comes this boy from my hometown, Jimmy Hood, through the doors there, and he has a couple other people with him that he works with. Like I say, I knew Jimmy got a pilot's license, and when he was in the Navy he was a machinist's mate.

But I can tell from the uniform that Jimmy's wearing he's not a mechanic, he's a pilot, and he works for PSA Airlines. As a matter of fact, when Elvis came to Columbus, Ohio, in about 1970, Jimmy didn't fly Elvis, but Jimmy Hood did fly the equipment and a lot of the support people. Maybe he didn't like the ride or something, Elvis said he'd never come back to Columbus and he never did. [Laughter]

Herman: So from Norton, you headed over from there?

Wallace: Yeah.

Herman: MAC flight or something?

Wallace: Actually it was a civilian airliner, it was a big DC-8, big, long four-engine jet. I always thought it was a 707 because it had two engines on each wing, you know, the wings were swept back. The airline was World Airlines. I'd never heard of World Airlines. It was huge. There was no separation between the coach people, the coach seats and the first-class seats. So when we walked in the left front of the airplane and you looked back through the airplane, you were looking all the way to the toilet, there was no walls or anything.

Herman: A stretch DC-8.

Wallace: Yeah, it was a dandy. So we sat down right in front, and the plane was, I would say, was about full, and we left right about midnight and the airplane departed. I remember looking down. It was about six or seven of us there on the plane and we all knew each other, we all sat together. I remember looking down as the plane would fly toward L.A. and you could see the lights and everything and you're looking down at the city, and then all of a sudden there was no more lights, you know, and we thought, well, hell, we're out over the ocean finally.

We went from there to Honolulu Airport and we landed there about four in the morning and we weren't there probably an hour half or two hours and we were back on the plane and the next leg of the plane was from Hawaii to Okinawa. The sun would have been behind us and it seemed like it just, you know, you'd just keep looking back and it just seemed like it took forever for the sun to come up because we were going about four hundred miles an hour and so, and the sun was moving about a thousand miles an hour, but it's coming after us all right.

So it was an eleven-hour flight from Hawaii to Okinawa. I didn't even think the airplanes could even fly that long. Fortunately, they could. We were in Okinawa probably about an hour, hour and a half, two hours, and then from Okinawa it was a straight shot into the Air Force base at Da Nang.

Herman: How long was it from Okinawa?

Wallace: From Hawaii to Okinawa?

Herman: No, from Okie to--

Wallace: From Okinawa to Vietnam, I would say it was about three hours. But it was eleven hours from Honolulu to Okinawa. When we were in Okinawa we flew into--

Herman: Kadena [phonetic].

Wallace: --Kadena Air Force Base, yeah. So I remember the plane lands and everybody's excited, you know, and anticipating what it's going to be like.

Herman: Was it daylight when you landed?

Wallace: It was.

Herman: Was it Saigon, in Saigon?

Wallace: No, we went to Da Nang.

Herman: God, you looked down, what the hell did you think when you looked down?

Wallace: Oh, we saw very little of the country. I would imagine we probably approached the air field from the north, so there was like a harbor there north of the Air Force base and there was a river that came out of that harbor and ran north and south, and the air base would have been west of that river and the runways would have been pretty much north and south. I know that because of where I would be assigned later on in relationship to where I knew the Air Force base was.

But, you know, you could look out and the plane's coming down and coming down, and pretty soon you'd see just a little bit of the hillsides and the hills and stuff there, and then the plane just zooms right on into the Da Nang Air Force Base. Somebody got on the plane immediately and told us, gave us a very short briefing about safety, what we can do, what we're supposed to do, immediately get off the plane. As I recall, there was nothing that appeared to be hazardous, like there was no rockets coming down or, to my knowledge, I don't think there was any shots fired at the airplane. I've read stories about that, but I don't think that happened to us.

We went over to this one area, and everybody was looking at the natives there, the people that lived there, the Vietnamese people, and they would be like sweeping the place up and sweeping the walkways and picking up trash and stuff like that. So that was my first experience of seeing Vietnamese people.

Herman: What was the feeling when they opened doors? Did you get this blast of humid hot air or anything?

Wallace: Not that I recall. I've read stories about that and I've heard several people say that. I don't remember that. I do remember when they opened the airplane up it seemed like they had--the power was probably--or the accessories like air-conditioning on a plane was probably turned off at that time. I don't remember anything. I've heard people say that it was a nauseating odor; I don't remember that. I've heard other people say it was just a terrible blast of hot air. It was uncomfortable, it was noticeable, I don't remember that. I remember that when we got off, it was hot. This would have been a week before, just a few days before Christmas 1967.

As I recall, we weren't at the Air Force base, I wouldn't think any more than a half hour. We were put onto a big metal--it's like a bus they haul livestock around in, it was a tractor trailer,

big thing, and the doors were in the sides of it and they were open. I think there was a chain across it or something like that. I remember standing right by the door as this vehicle took us away from the Air Force base and took us to the place, our temporary place where we were going to be spending the night and the next several days or whatever long it would take us to get processed in.

The name of the place we were en route to was called Camp Tenshaw.

Herman: T-E-N-S-H-A-W?

Wallace: Yeah. Yeah, Tenshaw, that's correct. It was right at the base, I would say on the southwest side or the south side of Monkey, of Monkey Mountain, and we spent the first night there. I remember--I still remember this, after--I don't know if we ate that evening, we probably did. Of course, we had eaten on the airplane. But I remember taking off the uniform, the dress uniform for travel, taking a shower and putting on clean dry clothes, the blue dungarees--dungarees, I think we called them--and the chambray shirt and a baseball hat, and feeling extremely relaxed. It was one of the most comfortable times. I still remember that, how comfortable I felt after that stop. I don't really recall the flight being that bad. It was a long trip, it probably took about twenty hours to get there. But I always tell people, make that comment about how comfortable I was after that shower.

So I'm sure we had breakfast the next morning, and the whole airplane load probably went to--I would say most of us probably went to Tenshaw. Some of them would have been people going to the Air Force base, so there was probably a dozen or so civilians on the airplane. I really don't remember that, I'm just saying there probably were. So the next morning we would have had breakfast and we started the orientation. An admiral came there and he welcomed everybody aboard, and then we had a short discussion from--one of the hospital corpsmen had something to say. He told us not to drink water out of the toilets, the sinks, or the showers. I remember this very well. He said it had a particular organism in it that would make you sick and he described the organism and he said, "If you don't know what that is, it's lizard shit." So everybody laughed about that. I remember that.

Then we had sat through about four hours of this orientation and we would take breaks, like every hour maybe we would have a break, they were trying to tell you how to, you know, what to do while you're here, what not to do and where you can go and what you can't do and where you can't go, and be respectful of the people that live here, the natives.

Then at one of these intermissions, one of the people who that was running the--he was like the narrator, or he was like the moderator, he was the one that was the organizer of this orientation, he wanted to have all the hospital corpsmen meet over here underneath this other shelter house. So we all went over there.

Herman: What kind of a house was it?

Wallace: A shelter, like you'd find in a picnic park or something like that. It was big enough to put a hundred people inside. As I recall, it didn't have any walls on it. We'd went over there and sat down on the benches. What they were doing, they were taking the hospital corpsmen out of this, or taking most of us out of this orientation. There was about eight guys that came over with me that I had known before, and I think all of us were put on a bus that afternoon with our gear and we were sent to the station hospital at Da Nang, the Naval Support Activity Hospital at Da

Nang. That was about ten miles south of where we were, almost directly south, right down what I thought was Highway 1.

Herman: When you had gotten your orders to go to Vietnam, the orders did not specifically say Naval Hospital Da Nang, did it?

Wallace: No.

Herman: You had to report somewhere.

Wallace: Yeah, it said Naval Support Activity Da Nang. I could have been sent, rather than the hospital, I could have worked at the dispensary at Camp Tenshaw, the dispensary at Deep Water Piers, the Naval Support Activity. Da Nang had other commands outside of the immediate area around Da Nang, Phu Bai. We had something at Phu Bai, we had one at Tan Mi [phonetic]. I honestly can't tell you which way. I think Tan Mi was up around Dong Ha. We had one Chu Lai [phonetic], which I think was still under the NSA Da Nang, Naval Support Activity Da Nang. It also lists those commands in the cruise book that I had, the 1968 cruise book that I had that you got to see.

So yeah, there was nothing on my orders that said Station Hospital Da Nang, that I recall. I was hoping that I would get there, because I would assume that that's where they would have the operating room. That was what my C School was, operating room technician, and I was hoping that that's where I would be sent, and I was.

We were there that afternoon, probably got there about two o'clock in the afternoon. It's probably a half hour drive down the road. Turned in our paperwork there in personnel there at the hospital, which was a small Quonset hut. Then we were taken up to the operating room supervisor's office, her name was Ruth Morelock [phonetic], she was a lieutenant commander, pretty gal. There were two other nurses there at that time who also worked in the operating room, Marjorie--Margie Warren and Joan Brouilette. I had known Joan Brouilette at the Navy Hospital at Portsmouth, Virginia. Joan was from New York or Boston, I'm going to say Boston, and all three of these girls were--all three of these operating room nurses were lieutenant commanders, Nurse Corps.

Herman: What did the hospital look like? Was it a fairly modern-looking structure?

Wallace: Well, for the most part it was Quonset huts. I don't know if they consider those permanent buildings or not. There were some buildings there that were made with plywood and frame construction, two-by-four construction. The area around the operating room, kind of like around the surgery area where we made up all the sterile supplies and saline and equipment and instruments and stuff like that, it did have a solid white wall right off the sidewalk there. It looked like a construction barrier that you would see if you were walking down the sidewalk and it's plywood. The only thing that was missing, I guess, from what you would be familiar with would be the graffiti. There was no graffiti written on it. There was a huge door that went into the side, it was probably a four-foot door, and it went right into this area where we stored all the towels, gowns, packs, extra instruments, things like that, stuff that we had. We had an area there that would supply all the operating area.

At that time, to describe what the hospital looked like, it was built on a slight hill going uphill away from where the helicopters would land. They would land out front. From that elevation there, the hospital went uphill and to the west and it went clear to the top of the hill, which wasn't a high hill, I don't think the elevation difference was more than, no more than forty feet, and this distance would have been close to two hundred feet from out in front of the hospital to the top of the hill, two hundred feet deep and probably forty-feet difference in elevation.

Also, again, I would say 95 percent of the buildings at that time were Quonset huts. It was exciting to look at it for the first time and to know that I was going to be stationed here. I thought that this was quite an accomplishment, you know, this is going to be a neat place.

Margie Warren was the girl who was working that day, and she showed us around the hospital, around the operating room. She showed us where everything is and how the rooms were laid out and where the operating rooms were. At that time we had four operating rooms that were in two different, not connected, Quonset huts, and each Quonset hut had two operating rooms. The one at the bottom or the one closest to the bottom of the hill had the operating rooms one and two, and then the one above that, which was on up the hill another seventy-five feet had the rooms number three and four.

Also at that time we had, which was every near that area, which was actually right down front where all the office buildings were, they were like lined up on an elevated sidewalk, we had two surgical what we called MUST units, M-U-S-T. I always thought that stood for Medical Unit Surgical Team or maybe Military Unit Surgical Team. I'm not sure what it stands for, but we called it the MUST units and we had two of those.

Herman: They were Army. I think the Army had developed those MUST units.

Wallace: They could have been, because I have also heard that those things were--their physical dimensions were compatible with the--I'm trying to think of the crane that the Air Force used, I think it's an H61.

Herman: Sikorsky.

Wallace: The crane.

Herman: Sky crane.

Wallace: Yeah, and that thing was supposed to fit right in the back of that thing. I never saw these things move. The dimensions of the room would have probably been twelve feet long and ten feet wide and eight or nine feet high. They were air-conditioned, they had lights in them. As matter of fact, we used to go down there and sleep a lot because it was so cool, it was extremely cool.

We had two of them, one we used almost exclusively. The first time we ever did use it was early on. I would say it was after the Tet Offense. We had a guy that had a wound, or anyway he ended up losing one of his legs and the problem that he had was, the infection was gas gangrene. One of the few times I ever saw this. You could squeeze his leg, the leg didn't appear to have any circulation to it because it was cool, cool to the touch. The color of the skin was not like what you would expect. But if you would squeeze the leg, it felt like his leg was

stuffed full of Rice Krispies, as you pour Rice Krispies out of the box, and if you would squeeze that, you would also leave impressions in the tissue in his skin in his leg of where your grip was.

Well, anyway, we operated this guy and took him--and then the next day--

Herman: What did you do surgically?

Wallace: We just removed the leg. It doesn't seem like it was any higher up than like--maybe all we did was take it apart at the knee, which is a very common way of doing that rather than--it was a very easy way to take the leg apart or separate something that was mutilated from what was viable. You could take it apart at the knee joint and then you still had a big nerve in there to deal with and the big arteries and veins and the connecting tissue that held it together. But it was much easier to do that than--and chances are he would have probably had to have had a revision later on, which would mean that the very end of the thigh bone, which would be above the knee, would likely be removed so it would accommodate--cosmetically accommodate--so that when he would sit down in a chair, if he was wearing a prothesis, that his leg that had been removed would not have a knee down here. If you see what I mean, the knee would be out here and the lower leg would have to be shorter.

My brother has this. My brother lost his leg and it was taken apart at the knee, but they never did a revision. So when you see him sitting, his lower leg, if his knee is bent at an angle, a right angle like this, his lower leg looks so much shorter than his unaffected leg. But my brother is very active, he plays basketball and he's a deer hunter and he climbs trees and shoots and uses a bow and an arrow for archery for deer, so for the activity that he does, this gives you a very wide, very strong support for a prothesis, on the other hand.

But that was the first time we ever used one of the MUST units.

Herman: I'm going to take a two-minute break. I just have to make a phone call. [Tape recorder turned off.]

Herman: The MUST.

Wallace: Oh, yeah.

Herman: You had just operated on this guy for gas gangrene and had done an amputation.

Wallace: Yeah, there's a little more to that I can tell you about. This guy was probably a Marine or an Army fellow, and he had been sent to us from some other place like 3d Med or Charlie Med or 1st Med or one of the other medical battalions. I can't even remember if he had--I'm sure he probably had some other wounds there. Maybe the reason he had this problem is he just had bad circulation or an embolus or something in the leg and it just wasn't working. He was sick.

So after we operate this guy and then we have to clean the room up and everybody was dissatisfied with that because it involved a lot of cleaning, top to bottom, everything that could be thrown out was thrown out. As a matter of fact, I think even the laundry was thrown out or it was incinerated.

Herman: Because of the organism, right?

Wallace: Yeah, it was very, very destructive. So it seems to me the next day, one of the guys that I worked with in the operating room, his name was Wayne Kenning, and he was from Chicago.

Herman: K-E-N-N-I-N-G?

Wallace: That's the way I would spell it, yeah. There's a picture of him in your cruise book. Wayne says he wants to go out to the hospital ship *Repose* and see some of the people that he knew that were stationed there, and I knew several people that were stationed there, that were assigned there, also. So he and I get out of there somehow, get out of the hospital the next day, and we go over to, I think a place called Deep Water Piers, which is up around Tenshaw, which would be like on the west side of Monkey Mountain. We get on a launch that takes us out into the harbor about, I don't know, five miles or however far, out to where the hospital ship was, maybe ten miles, I don't know. It was a pretty good-sized Navy vessel, probably about a forty-foot boat.

So we climb up the side of the boat. You know, this is the first ship I'd ever been on in my life. Now, this thing's not tied up to a pier, this is out in the water, and it's not moving. I guess it was anchored out there.

I don't think I mentioned this earlier, either the next morning or maybe later on that day, the guy that we operated on in the MUST unit with the gas gangrene, he was transferred, he was put on a helicopter and flown out to the *Repose*. The reason they did this is they had a decompression chamber there which would be like for diving accidents, SCUBA diving and air emboluses and things like that. The advantage of this thing would be--this thing also had the capable of whoever would be inside it would be subjected to not only a 100 percent oxygen environment, but also they could increase the atmospheric pressure in this thing. I don't know how much they would do that, maybe only one time, but this would increase the oxygen metabolized in the--it increased his healing capacity, I guess that would be one way of saying it, and that was the reason for doing this. Again, this was a hyperbaric chamber that was used and originally designed for diving accidents. This thing was probably about ten or twelve, maybe fifteen feet long.

Herman: The *Sanctuary*, which is up in Baltimore, which is the sister ship of the *Repose*, it's still on there.

Wallace: Is it?

Herman: The hyperbaric chamber is still there, yeah.

Wallace: Well, it could very well be that the ship that we went out to see was the *Sanctuary*. It seems to me that the first one, the first one that I went to see was the *Repose*. The numbers on them were 16 and 17, and I can't tell you which one was which. I think the 16 was the *Repose*.

Herman: Yeah, 17 is *Sanctuary*.

Wallace: Okay. Anyway, so this tank as tall as I was, and it was almost sitting right down on the deck, and it was outside, and there was a hospital corpsman in there crawling around wearing a pair of cut-off jeans, and the patient was in there. Somehow I think we got a note to this guy and told him who we were. He looked great to me, he appeared to be happy and was comfortable. I can't tell you how long he would be in this environment, maybe twenty-four hours, I don't know, never did hear too much about him. That's the only time that I recall that we--

Herman: You went out to the ship?
Wallace: Oh, no, we went out there many times. That's the only time that I recall ever seeing somebody that we operated on or that I recall seeing that hyperbaric chamber. I don't remember seeing it any other time. That was the only time I ever took a launch out to the ship, also. The next trips that I went out there were always on helicopters, they were medi-evac flights from our place there at the station hospital out to either one of the two hospital ships, the *Sanctuary* or the *Repose*.

The very first time we were out there, when we got ready to leave, we thought it would be fun to fly in a helicopter. Neither Wayne nor I had ever flown in a helicopter. So well, hell, that's what we want to do. So we waited around and here comes an Air Force, the number on it was 43, that's the model number, like F-15 or something like that, it's got a nickname, Husky. It's a funny-looking helicopter, it had a huge engine exhaust stack that was directed out the back of the helicopter and down. It looked like a big piece of pipe about three feet in diameter. That was the exhaust pipe. The whole back end of the helicopter was open. This thing looked a little bit longer than a bubble. It had two crew members that flew the helicopter, and this is what we flew off of the ship with, and they took us back to the Air Force Base at Da Nang. We wanted to fly back to the hospital, but they weren't going there.

The interesting thing about this was the rotor set at an angle and they pointed away from, and the rotors were go like this, like that. Again, the nickname of it was Husky. The Air Force fire protection, the fire department, the crash airfield firefighters, adapted this helicopter to be used in remote crash sites where they had a portable fire extinguisher unit that could be picked up with a cable and lifted off the ground and taken to a remote area like on top of a hill and they could set it down, they could drop off two or three firemen so they could put this fire out. That was one of the applications that that helicopter was used for. That's the only time I ever flew on that particular-type helicopter, and I can't even remember ever seeing another one after that. I know they don't use them now for anything. Forty-three was the number on that.

But the next time I flew out there was at nighttime. Whenever we would send a medi-evac flight out to the hospital ships, it always seemed to be at night. That was good, I guess. This was good for us because a lot of the patients we would send out there were potential surgery people. If we could send them out to the hospital ship, that meant that we wouldn't have to operate on them. Being on the selfish side, being a selfish thought, after a while you got tired of doing this and it just seemed like you never got over being exhausted. You were constantly worn out.

Herman: What kind of patient load did you have at this point? This was the winter/spring of '68.

Wallace: Yeah, it would have been after the Tet Offense, because there's no way we could have gone out there during February. We were just too busy, we would not have been able to get out there. As a matter of fact, I don't even think they could have spared--let alone an operating room technician to send out there to be gone for an hour. I don't think they would even been able to spare a hospital corpsman that would have been one of the guys that worked in triage or receiving or even off of one of the wards to go as a "go-fer," you know, to have a medical trained person with them on the helicopter.

Herman: When the Tet Offensive happened, obviously the schedule changed the hospital.

Wallace: Yes, it did.

Herman: How noticeable was that? Did you know what was going on?

Wallace: Once we started--there were several days before the Tet Offense started. I mean, this may have been like even at the end of December where we would have worked a twenty-four-hour shift. When the next shift comes on the next morning, it could very well be that they worked a twenty-four-hour shift. Now, we may have done that once or twice or maybe even three times before, I'm going to say, about the 30th of January, 1968 came about, and that's when our activity increased to the point where there was never any more busier time for me when I was in Vietnam than there was during that first three weeks during of February and the last day or so of January.

Herman: Prior to Tet, how many patients would have been a normal load for a day for surgery purposes?

Wallace: In the operating room, even if we were working twenty-four hours, I would say we had four operating rooms that we would have used and even then we would have still had the dressing changes that we would have been doing in the morning. We did those in the two operating rooms up above rooms three and four, and those usually lasted to about one o'clock or something like that in the afternoon. We'd start those at seven, whenever we started, seven o'clock or eight o'clock in the morning. These were people who had already been operated. We would take the dressings off, irrigate the wounds, debride any devitalized tissue, things like this, and then redress the wounds. The wounds that we were dealing with were extremity wounds mostly, and very seldom would we ever have someone long enough to where we would actually put sutures in them to close the skin or the wound over to proximate the wound edges to make less of a job for the body to heal it.

Herman: So you were leaving these open for drainage purposes.

Wallace: They would be packed full of gauze soaked in a variety of different solutions. Betadine was one of them. Neomycin sulfate was another one, it looked like lemonade, it was just kind of a yellowish/greenish tint to it. It looked like green Gatorade, not quite that green, I guess. Bacitracin was another one. Another one was called Benel's. Benel's solution was a glycerin, acetic acid and--I'll think of it sometime, but there was a third item in Benel's solution. It was named after an orthopedic hand surgeon in California, Benel.

Anyway, we were trying a variety of things like this to soak gauze in that would help make an environment to help keep the bacteria growth down. Betadine was probably as good a thing as we used. We always had plenty of it and we would use the thinner solution, not the soapy solution. We would use the paint, what we called the paint. It had another name, I can't remember. I mean, it had another name like paint or liquid or something like that. It could actually be sprayed, and I'm trying to think, did we have those sprayers then or did we have this when I was out of the Navy.

But anyway, to give you an idea of how many people we would operate, let alone the dressing changes, on the average I would say we would probably have at least one craniotomy, two to four cases where we were actually opening the chest, six or eight cases where we would actually open the abdomen, and the rest of the cases would be multiple wounds, multiple shrapnel wounds to the extremities, lower extremities.

Herman: Mine stuff.

Wallace: Yeah, mines, booby traps, things like this, rockets, shrapnel. This was probably 80 percent of the patients that we worked on were lower extremity wounds, I'm just guessing. I'm sure there's figures on that information, but that's just a guess. As an operating room technician at that time, you had to be able to do things besides pass instruments to doctors. This is a way I think about it now. You had to be able to pick up a pair of forceps, tweezers, and a knife and cut somebody. I think everybody that does this for the first time is probably a little apprehensive, they don't want to make the hole too big. What you're doing, the first thing you would cut would be the skin and you're removing a football-shaped, an oblong-shaped piece of tissue away from the wound site. You're removing the devitalized skin and tissue almost immediately below it, then you would continue to remove tissue that was blasted, appeared to be blasted or not salvageable. The wound would be bleeding; you would tie off bleeders. We also used the electric cautery machines, the Bovie machines, to do this on the smaller ones.

Herman: What were they called, the cautery machines?
Wallace: Cautery or electrocautery machines. The particular one that was very big at that time was made by a company called Bovie, B-O-V-I-E. It may have stood for someone's--five different guys' names, the first initial of everyone's last name or something. It looked like an old-fashioned radio that Walter Winchell used to be broadcast over. It was about thirty inches wide and about twenty inches deep and stood about this high. It was green, it was just their color schematic. I imagine if they use the same thing now, it's probably no bigger than that radio. It was a big heavy machine. It had heavy cables, usually came with an explosion-proof plug, especially back stateside, big plug. It was about this big around and you opened the lid, opened the receptacle and slide it in and turn it and then shove it all the way in, and that was an explosion-proof plug.

It had a set of pedals on the big thing where the two pedals were and that was controlled by the operator. One pedal, I believe the right pedal, was the coagulation pedal and the other pedal was the cutting pedal. This thing had the capability of--and then the third--let me just continue to describe the machine. Then there was a ground plate or ground wire that went from the face of the machine over to the patient, and this wire was probably about six or eight feet long and it had a big stainless steel shiny plate that was either slid underneath the back or the buttocks or the back of the thigh, and this was the contact. This always had an electrode paste,

the jelly, and this would make the circuit between the patient and the machine and back to the operating--the cautery tip that you're using, and it was like a pencil, about nine inches long, bigger around than a pencil, about a half-inch in diameter.

You had the ability to take different tips out of it and you could put a thing that looked like a heavy needle, just a point. The one that was used most common looked like a knife blade, it was about an eighth of an inch wide and about an inch long and probably a thirty-second-of-an-inch thick, it was real thin, and that was usually the one that was used the most. They also had one that was a circle that you could use to make a scoop. It actually just cut the tissue right out like that. Then they also had one that they ended up using in GYN surgery, it was called a figure four. We didn't have any use for that.

But what you would do when you had these two settings on top there, you had a coagulation setting which would increase or decrease, a rheostat. You also had one for the cutting side, and there was a dial on there and you'd just twist this thing up. As I recall, there were numbers on it and you'd just dial it up there to whatever you want. For the average individual, thirty seems to be a number. I don't know, that may not be correct at all.

But when you got ready to use this thing, if you had a small bleeder, like we'll say bleeders directly underneath the skin in the fat, you would step on the pedal on the right side, you'd just touch this pencil to it and it would smoke it. It would just psst, it would burn it. These things are still used today, but like I say I'm sure they've got to be much smaller. This thing had to have weighed, this machine with everything had to have weighed two hundred pounds. It was on rollers and it was easy to move around, it was easy to clean.

Herman: What did you have for like aspirators? What did you use, a Gomco [phonetic] or something?

Wallace: Well, we did have those. Usually that was probably set up for the anesthesiologist.

[Begin Tape 1, Side 2]

Wallace: Okay. You asked me about the suction machines or the aspirators. Besides what the anesthesiologists used, which may have been a portable Gomco plug-in unit that ran off of an electric motor, I'm trying to recall exactly what our suction machines looked like. They may have been the same thing.

In any case, the suction machines that we would have used--let me start at the operating table and work backwards. First of all, we would have had the suction tip, there was a variety of different tips, about three different tips that you could use. If you were doing a neurosurgical thing, you had a very small tip, it was about as big around as--about an eighth of an inch in diameter. This would limit the area that the suction tip has access to. But if you were working on someone's belly, we would either use a pool suction or we would use a Yankour [phonetic] or Yanker or Yankee, sometimes they called them Yankees. Back then these were stainless steel, and now they're a throwaway synthetic-like plastic.

From the suction tip we had the surgical suction tubing, which was usually about a ten-foot piece of very good latex tubing, and that would be forced onto the backside of the suction tip and then the other end of it went onto the suction bottle which was on the floor. Now, this thing could be kicked around for your convenience, you could bump it over to the left or right or move it away from the table. The hose normally went right down off the side of the table and

right onto the floor and then across the room, two or three feet and then on to the machine, onto the suction receptacle, which was where the blood and the fluids and things like would be collected.

Now, the question that you've asked me is how did we supply suction to the bottle that was on the floor. I don't remember that we had built-in suction in the walls like you would in a stateside hospital. So that could have very well been supplied--the source would have very well been a portable Gomco suction unit. That's the first time I've thought of that. I don't think I've ever thought of that before.

Herman: When I was in the Air Force I was a dental tech, and that was the heavy-duty machine, was the Gomco, and it had the collection jar right on there, the stuff could go right in the jar. You could see where it was, it was clear, and you could see where you were, whether you needed to empty it or not.

Wallace: Well, the thing that we had on the floor was in a roller. Well, so were the kick buckets. The kick buckets usually had three wheels and it was a frame and the bucket was--everything was pretty much stainless steel. But the thing that held the suction bottle was made for the suction bottle and it also had wheels, and I would say this thing would hold three quarts, it may even have been as big as a gallon. If you would doing something like a head, where you're using a lot of irrigation, like a craniotomy where you're working inside the head, or even the abdomen, I remember many times emptying suction bottles, and you'd unscrew the lid off of it and just turn the thing upside down and just dump this huge clot, it wasn't hard like crusty, it was just like Jello, of clotted blood, and you'd just stand there and tramp on it until you broke it up in pieces, and the water, we just hosed the floor down and wash all this debris down the drain.

Back then when you were nineteen years old, you know, anything that goes down the drain goes somewhere else, you don't have to worry about it. Eventually those things had to be cleaned out. There would be sand in there we would have off of our boots. There would be tissue that would go down the floor drain, which was pretty much right in the center of each operating room, in the Quonset hut operating rooms.

The question you've asked me about that, that's interesting, because I don't remember us having vacuum receptacles on the wall like--

Herman: They were probable portable.

Wallace: Yeah, I'll bet you that's where they came from.

Herman: I'm sure, yeah.

Wallace: But like I say, there was always a big receptacle between the operating table and the source of the vacuum, the source of the vacuum being the Gomco machine and the operating table being where the suction tip, where the stuff actually originated from, the fluids and blood and stuff like that. That's an interesting question. If you hadn't asked it that way, I might have flashed back a year and a half before and said, well, it's real simple, you just had a gray hose, or I'm trying to think what color the hose was for the vacuum, it might have been black. You just plug it right into the wall and then you had a vacuum pump and all that stuff was piped right into the operating room. Like your oxygen was piped in.

Herman: As I recall the Gomco machine, we had just had surgical tubing. It had the tip, the aspirating tip, and it was kind of one of those graduated things so you could force a hose on it.

Wallace: Yeah, a force cone.

Herman: It wouldn't pull off. It wouldn't pull--a cone, right. It wouldn't pull off. It was kind of a yellow, I don't know, surgical tubing.

Wallace: About the color of a manilla envelope.

Herman: Yeah, right, manilla envelope color.

Wallace: I would say, and you would probably agree to this, if you recall what the unit looked like, it was painted brown, dark brown. Do you remember that?

Herman: It was green, the one we had, it was kind of a green color.

Wallace: Maybe they were different colors.

Herman: Yeah. This was a dental Gomco, though, so it was different. You didn't have to aspirate as much.

So you remember those things in the OR, the other kinds of instruments that you had. Do you remember what kind of anesthesia machine you had?

Wallace: Yeah. As far as the name of the anesthesia machine--

Herman: Byrd [phonetic], was it a Byrd machine? Sometimes I recall Byrd.

Wallace: The word "Byrd" to me would be--it could have been. I honestly can't tell you the name of an anesthesia, the manufacturers of the anesthesia machines. The word "Byrd" to me was--when I first became familiar with it in medical stuff was a breathing treatment machine. There was another one called Bennett. I think the Bennett was the earlier one.

The Byrd machine was used to get somebody who had had--you could use it on any hospital patient that was in a bed. The idea was to exercise their lungs. They were too sore to take a deep breath themselves, especially if they had a tracheostomy tube in them. You would stick this thing on there and this thing was set up by a therapist, inhalation therapist, and when they would begin to inhale, it would trigger this thing and this thing would open and it would just fire this big blast of air in through this tracheostomy tube and inflate their lungs from the outside. I mean, they don't have any control over it.

The idea was to get the lungs to expand out and get this air in there and allow this air to absorb moisture that was in their lungs that was not being moved out of there. What this did for the patient was to prevent long-term hospital problems like pneumonia, which would kill a lot of people back in the forties. People were laying around a long time, I guess, in hospitals because since they'd been operated on, they didn't want to move them for two or three weeks, you know,

they wanted them to heal up. They don't do it that way anymore; they try and get the people up and get them moving.

Herman: You're talking about the schedule. You said you were just packing in patients. Well, before you said you had a twenty-four-hour schedule,

Wallace: We had three or four days that I remember where we worked right around the clock, and then when the people came in the next morning at seven, they may have worked--I mean, it could very well be that you--yeah, okay, let me finish that part first.

There were days where we would do that, and this happened before the Tet Offense, but there was only like three or four days that we did this. Every day that we were assigned, everybody that worked on a--there was like two teams, A and B shift, or what do they call it in the Navy, port and starboard?

Herman: Yeah, do your starboard watch.

Wallace: Okay. At that time we had like four men that were assigned to one--they were on the same port or starboard unit, but they were assigned a breakout number or the duty team or something like that, but we called it breakout. There was four guys. I can remember two different groups. One time it was Gene Blount [phonetic], who was from California; Steve Rose, who was also from California; Tom Newland, [phonetic] whose dad was a colonel in the Army; and myself. One other time it was Blount, Rose, and I and someone else and I can't remember the fourth person.

It could very well be that when everyone else was released and could go back to the hooches or the barracks, these four guys, whatever unit it was that particular day of the breakout team, those guys would stay there, regardless. They would stay there 'til the next morning. They had facilities there for four beds. It was called the breakout room. It was easy to sleep in there because it seemed like you were so tired, but it was right beside the room where the autoclaves were, so it was hot. You'd just go in there and lay down on that bed and you'd be sweating. I mean, there were days when I remember many times that somebody had to come in and wake me up at ten o'clock the next night and tell me to get out because they wanted to go to bed. I had stayed in that bed part of the night and most of the next--and fifteen, sixteen hours all the next day. I'm trying to remember if that was your question.

Herman: But then you noticed one hell of a change when Tet came, didn't you, about the 30th of January or around there?

Wallace: Yeah, for years that was when--for a long time I never, ever really sat down and talked to any other Vietnam veterans. I would just tell people these stories. That's maybe why I can remember a lot of them. But I always would mention that day, about the 30th of January in 1968, that's when we at the hospital noticed a big increase in the casualties. In addition to getting casualties by way of helicopter, we had these cursed buses. I mean, I see buses over here at Fort Myer that are hauling Marines down to the Iwo Jima Memorial, they're taking the Army Band. It wasn't a big Greyhound, it was a--

Herman: Like a school bus.

Wallace: Yeah, there was a blue one and a gray one, and we called them the goose. The Blue Goose came from the Air Force Base or it came from the Air Force, and the Gray Goose came from the Navy wherever. I don't know where they came from, but these things would bring wounded into the hospital and when you'd see--you'd get down in front, around the triage area and you'd see that thing sitting out there, it was just, "Oh, shit, we got more."

We would go for like--the first twenty-four hours, I think most of us were young enough and strong enough and aggressive enough that everybody could deal with the first twenty-four hours. But then when it goes beyond twenty-four hours, that's when your alertness begins to fade and your desire to be helpful and, "Okay, well, we've proved that we can do this, you know, now we don't want to do it anymore. Let's get back to the way it was before where we only worked like fourteen hours a day."

So when this thing started, it was just an incredible amount of activity. This not only involved the people from the very beginning, from the people in receiving, which was a Quonset hut, which is right beside the triage area. If things weren't real busy, the causalities were taken directly into this Quonset hut called Receiving One. There was also another Quonset hut on the other side of triage which was fifty feet away, and it was called Receiving Two. But by the time I got there, Receiving Two was not used for combat casualties, it was the sick-call place, as I recall. That's where they kept all of our health records and stuff like that. About the only time I ever went down there was to sign off my gamma globin shot, which I never took. I'd go down there and stamp it and sign my name and go back to work.

But anyway, at four o'clock in the morning you could go down to the triage area and there would be--well, let me think. The triage area had like a sidewalk that came right through the center of it. I would say from one side to the other it was probably fifty feet wide and it was about thirty-five feet long. The sidewalk would cut this in half and it came from the outside right through the center of the triage and then started up this hill right through the middle of the hospital. The sidewalk was outside.

There was a shed, a huge roof that went from the crown or the top of the arch of one Quonset hut like this, this would be as you're looking at it from--you're looking west and the heliport's out here, it would go from like right here, I don't even think it was weather--it might have went a little further, I don't know, so that the rain would run off the other side. We'd go from the top of this Quonset hut over to the top of this Quonset hut.

As a matter of fact, over on this side there was a space there about this big, and the way I remember that is--and this shed covered the whole triage area, and underneath this triage area we had the one side that was used most often, which was right beside the Receiving One Quonset hut, and that's where we had the IVs that were already plugged into the glass bottles. Back then we used glass bottles from Abbott and whoever else we were buying IV material from. Most of that stuff was ringers, lactated ringers, Hartmann's solution. Then tape. This was a well-lighted area and there were sawhorses there. The sawhorses were used to set the litters on, the stretchers. The guys would carry things in and set them right on the sawhorses and you had access all the way round this individual, you know, for removing clothes, getting information, name, the unit that he was assigned to, things like that.

Herman: These people were coming in, they had been given some rudimentary treatment in the field by a corpsman, let's say.

Wallace: Some of them oftentimes had already been operated on like at a battalion aid station, like 3d Med or Charlie Med or 1st Med or someplace like that. I think the 1st Med was about ten miles from us over at Freedom Hill at Da Nang, that was probably the closest, at that time, would have been closest combat hospital to NSA Da Nang. Third Med and Charlie Med, I may be mistaken, it seems like there was about--there was one at Phu Bi and I think one of them was at Dan Ha. Those were both up north.

I have pictures of the triage area. My friend Florence Beatty [phonetic] took a picture of it. It had to have been taken at night because all the trash is off the floor and all the IV bottles are hanging up and ready to go and there's no casualties. So it had to have been like four or five o'clock in the morning, because that place was usually jumping, usually busy.

I mentioned a moment ago of why there was a space between this shed that went over the top of triage area, there was clearance between the top of this shed and Receiving Two over here on the south side of the triage. On the other side of the Receiving Two was where we stored our pressurized cylinders of oxygen and nitrous oxide and I don't know what else was over there. But we had this big guy that I worked with and his name was Mark Barker, he was from St. Louis and we called him Man Mountain. He was big.

So many times we would have a family of Vietnamese that would be brought in that were wounded, maybe Grandma was wounded and then here comes Grandpa and Mom and Dad and three or four of the grandchildren. We had eight or ten people getting off of this UH-1. The Army seemed to be bad about this, maybe that was what they were told to do, but it seemed like they always came in on a UH-1. There would be six or eight people climb off of this thing, one person wounded. These were just innocent civilians oftentimes that were caught up in whatever was going on.

They would bring in things like pots and pans, I suppose they were trying to sell them, and they would bring in popcorn. I don't know where that came from. Oftentimes they would bring in charcoal, and this charcoal would be in huge gunny sacks as big around, you know, eighteen, twenty inches in diameter and four feet long. This thing would probably weigh fifty or sixty pounds. But we would tell these people to put their stuff over here against the Quonset hut, the side of Receiving Two, and what we would do, we used to have access where we could get steaks at night from the chow hall and we made ourselves a grill back at the hooch.

So Barker would come over there and somebody would distract these people, and Barker would take this huge bag of charcoal and throw it up over top of the Quonset hut and it would go right over the top of this thing, and all of a sudden it's gone and nobody knows where the hell it went. Then we would run over there and grab this thing and carry it over there and put it down in the--

Herman: These weren't briquets, these were--

Wallace: These things looked like big chunks of coal. I mean, they were real charcoal that they'd cook out on a hillside. They'd just take their wood and pile it up and then cover it to keep the oxygen out of it. What you're doing is distilling the hydrogen and carbon monoxide off of it and methane,and that would burn. If you could collect it, you could burn that stuff.

I'm saying this because my dad told me how he used to see the people in Iran, during World War II, how they used to make charcoal. He said it would be a huge pile of wood that would all be covered over with mud and they would just distill this wood, they'd heat it and there would be no oxygen in there to unite with the hot gases which would produce light and heat,

what we call fire. Then maybe there was a fire on top of it, they were flaring this or burning this gas off it, but when the gas stopped burning, then the charcoal was done.

I even did this in experiments in high school when I was a kid. I would do it with a coffee--the old-fashioned--remember the oyster can, coffee cans?

Herman: Sure. Had the little thing, a key that you had to

Wallace: Okay, this is what we would do. I'd take a piece of wooden board, a one-by-eight made out of pine, and I would cut it up in pieces about, I don't know, less than a half inch, just strips right across the end of it, and turn that piece up on end and just smack it with an axe and chop up all these little pieces. You take this coffee can, throw these pieces of wood in there, put the lid on it and poke a nail hole in the top of it, set it on the stove and you put on a Bunsen--in school we had a Bunsen burner. In the house, you stunk up the house. Set it on the stove or whatever, and that's your fire source.

Now, once you start heating this, the gas will eventually become heated--the fuel inside the wood, you're cooking this gas off there and it will eventually purge all the air containing oxygen out of this container. Then what you do once you start doing this is you take a match for a fire source and you put it up there where that hole is, and eventually that hole will start to burn, because that gas has reached its ignition temperature, and when it comes out of that hole it mixes with oxygen, Then once you light it, it will continue to burn until your charcoal is done. People would watch this and watch it and watch it and watch it, and pretty soon the fire would go out.

Herman: Then you know it's ready.

Wallace: Well, the trick to it is don't put five pounds of wood in it, put like six or eight little cubes, because if you do, it's going to take forever.

So anyway, we would the charcoal to cook the steaks with and stuff like that.

I kind of want to back up a little bit. I know I got a little long-winded there. Sorry about that.

Herman: It's all right.

Wallace: But earlier you had asked me about the anesthesia machines. Even though I worked in an operating room two years after I got out of the Navy, I cannot tell you the name of the machine, the companies that made anesthesia machines, and Byrd could have very well been one of them. The anesthetics that we had access to, I know we had ether there and we probably did use ether. Ether was a very reliable anesthetic. It was a liquid, for anyone listening to this that has never seen it before, it's a clear liquid. It has, I think, a pleasant odor to it, but it's explosive. It's heavier than air vapor, extremely explosive.

We also had a stuff called, these are the inhalation-type anesthetics, we also had nitrous oxide, which is referred to as laughing gas, N_2O, I think is the number on it. It's also lighter than air gas. And nitrous oxide by itself did not have enough anesthetic properties to completely make someone unconscious. Nitrous oxide was always mixed with one of the other anesthetics that we had, like ether, fluothane, penthrane, halothane. There's three names I just mentioned, two of those are the same. Two of those are the same thing. I think it's penthrane and halothane

are the same and fluothane is by itself. But nitrous oxide was always used for general anesthetic. We probably had cyclopropane, which was only in cylinders, as well as nitrous--

Herman: What was it called? Cyclo--

Wallace: Cyclopropane, yeah. It's also an explosive anesthetic and it's not used anymore. I guess the big advantage of cyclopropane was it was very fast-acting and it had an advantage in gynecology cases like hysterectomies and stuff like that, maybe Caesarian sections, it would have an effect on the blood vessels in the uterus, it would allow them to contract. This is information that was given to me a long time ago. That's what I remember about cyclopropane. They used to say you could turn the thing up on full, take a deep breath, hold your breath and you would just pass out because it worked so quickly. I don't think cyclopropane had any odor to it. Most people that ever talked about the smell of the anesthetic agents, about the only thing they could ever perceive through their nose was the odor of the delivery equipment, the mask, maybe the black rubber hoses which we used to use. Now, all that shit's thrown out and disposable.

The other thing that we had access, we always had access to sodium pentothal. It was a liquid and it was used intravenously, we used the two and a half percent. It came in about a 250 or 500 cc, or both, bottle. It was like a yellow powder and you would mix, I think if you mixed 250--maybe it was a 250 cc bottle. If you mixed 200 cc of saline with it, it was the two and a half percent solution. If you mixed 250 cc with it, it was a two percent solution. We always used the two and a half. Extremely alkaline, it would not promote bacteria growth. You could mix this stuff up, the anesthesia corpsman did all this, they would mix the stuff up in a bottle, just stayed right on the anesthesia machine. This stuff was very fast-acting. An adult that we would operate on, we would give him about ten to twelve cc's of thiopental sodium or sodium pentothal. From the time the stuff was injected into the IV until the patient was no longer moving was maybe as much as twenty seconds.

Herman: Really, that fast.

Wallace: Oh, yeah. I would do this for people that would ask questions about this and I would just lay down, I said, this is what it's like. Okay, right now the guy's--you tell the guy you're going to give him the medicine in his arm and the next thing he's going to notice maybe is a taste of maybe crackers, soda crackers, in his mouth. Then after that you're going to feel very lightheaded, and then the next thing you're going to know is you're going to be awake.

Apparently, with pentothal there was no in-between, there was no like dreaming about dying or anything like that. You're standing there talking to these people about baseball or something like that, and the next thing you know you're awake, you know, your operation's over. No in-between. I'm sure if you had a chance to talk to some health-care people--

Herman: I've had it, I know.

Wallace: Yeah. Well, I never have. I never have.

Herman: For dental surgery once. Yeah, just woke up, that was it.

Wallace: Yeah. The pentothal was only used to put people to sleep. It bypassed about three stages of--or it bypassed the anxiety stage. It was just an incredible thing to use, it was very quick, and once the person was unconscious, you didn't use any more of it. You would put the mask on the face and turn the oxygen flow up to 100 percent and, I don't know, flood the anesthesia machine with--you had all the bag that you were squeezing to force the air into the person was filled with 100 percent oxygen. If this was a case where the person was going to be under an anesthesia for a long time, then likely we would put an intratracheal tube in them. There was a couple other drugs that we used to make sure that the vocal chords and the larynx did not have any spasms. Visualizing this structure, in order to put this tube into them, it made it easier. It didn't cause you any problems. You didn't want to have a laryngospasm with somebody who is unconscious, you'd really go downhill quick.

Herman: Did you do any spinals?

Wallace: Oh, yeah. Yeah, we, as the people in the operating--the doctor, the anesthesiologist did them, we also had a nurse anesthetist there who did them and hospital corpsmen did them. I remember about that time somebody came out with a disposable spinal tray, it was about the size of this book here. It probably had two spinal needles in it. It also had a big needle in it, which was about an inch and three-quarter 18-gauge needle, big needle. It came with the pontocaine--dextrose, pontocaine and saline, there was three vials.

The dextrose was dextrose and water, the other one was normal saline in an ampule all by itself, and then the third ampule was the pontocaine. Most of the time we used the dextrose, this would give you what they call a lighter than spinal fluid, it would be a hypobaric, as I recall, hypobaric spinal solution--medication. That was used most often, hypobaric spinal, which means in relationship to the spinal fluid, the solution that you're injecting in there is lighter than that. It was hyperbaric, it was lighter. I'm sorry. So I stand corrected.

Anyway, so these were all the things within it. It also came probably with some sponge gauze, and I think the person who had the gloves on was going to actually do the spinal, the other guys in the room would pour the Betadine out and this is what you'd paint the back with. You had a drape there that would slide right up against the buttocks and we always tried to do the spinals, if we could get them to sit up and turn to their right or left, they would be sitting on the side of the operating table with their feet on a stool and we would have them lean forward with their arms in their lap like this and try and relax the muscles in their back and allow the vertebrae to go from like this to like that.

Herman: To separate.

Wallace: Yeah, it was easier. If you could keep them sitting upright it was easier to visualize everything and direct everything, whereas if they were lying on their side, and some of the guys did it that way, I don't recall that I ever did it that way. They would do it that way also, but it seemed like we all had better luck doing it when the person was sitting upright.

Now, if we could give someone a spinal and do the operation we needed to do, we would do that rather than give them general anesthesia because it made their recovery less complicated for the recovery room people, they didn't have to be monitored quite so well, and it wasn't as dangerous because you didn't have someone who was asleep. You had not really blasted them with the general anesthetic technique.

Herman: So they were fully awake or partially awake with that?

Wallace: With the spinal?

Herman: Yes.

Wallace: Yeah, they were conscious. Yeah, they were awake. We did a lot of spinals for dressing changes because you've got someone who's got a lot of wounds and you're taking gauze out of there, and oftentimes you're going to end up cutting away some of the tissue.

Herman: Devitalized tissue.

Wallace: Exactly, that did not appear to be too bad when you first did the original operation and the dressings, and now you're doing the changes and this doesn't look too good. It would be difficult in most cases to get the gauze--the gauze would adhere to the wound or the wound would adhere to the gauze, the tissue there, and this would be very painful for them.

If someone would have an uncomfortable feeling--and we always--you never gave anybody a spinal unless you had an IV on. The reason for this is if you ran into problems with the spinal, you always had a drop in blood pressure when you give someone a spinal because the level where the spinal sets up, an expression, say like right about here, that'd be probably about the average, from there on down everything relaxes, so the blood vessels dilate. So now you've got a bigger system to circulate blood through than what you had, but you still only have the same volume of blood. You always see a drop in blood pressure.

The only problem, the other thing that we ran into occasionally is because this medication we were injecting into the spinal cord was lighter than the spinal fluid, it would float and--it would not float. Anyway, let me explain to you what would happen. Once the medicine was injected into the thing, you took the syringe off of the needle, you pulled the needle out and put a piece of gauze on the thing and you held it for a few moments. You'd probably have this person sitting another ten to twenty seconds, and then you would assist this person to lie down. We would always keep this person somewhat head-up. You never wanted to lay someone down with the hyperbaric spinal, because the--and I may be mistaken in my terminology. In any case, if you lay this person down too soon this medication would float up the spinal cord and instead of having a level of anesthesia from here down, like at the bellybutton or a little bit higher than the bellybutton down, you would have a level of anesthesia from here down, from his ears down. You see a terrific drop in blood pressure and then you're working around and you're doing different things and you happen to look down at this guy's eyes, and the guy is terrified. He knows that something has happened, and what has happened is he can't breath.

So if you don't notice this--and we're always right there and we always did and it happened, I don't know, not many times, I can recall it happened at least, not necessarily twice with the spinals that I did, but I can recall at least twice that it did happen. So what we do at this time is we just talk to the guy and tell him why this happened. We say, "We're going to give you some medicine and now you're going to go to sleep." So we give him a little bit of pentothal and he goes to sleep and we go ahead and buckle a face mask on his mask and turn the ventilator on him. The ventilator would exercise his breathing mechanism and allow him to breathe.

If you ever see that and when you do see it, I mean, it just catches your eye, because this guy has got a terrible look of fright, he knows there's something wrong and he can't do anything. Like I say, I can recall at least twice that that happened. I don't think it happened with me, I don't think it happened with anyone that I did. Okay, that was a little bit about the spinals.

One of the other things that was in the spinal tray was this needle, and the needle was referred to as an introducer. A Vietnamese person would be much smaller back then than an American-sized person, so we would use this introducer and we would direct it in in the direction we want the spinal needle, which is going to go inside this thing to go. The introducer would pass by--

Herman: Like a funnel? Was it sort of like a funnel?

Wallace: No, like a obturator or a passageway or something. It gets you past all this tough fibrous tissue like the skin was--well, the skin was--seems like it's easy when you cut yourself. But the skin was actually pretty tough, not necessarily to get a spinal needle into, but--well, anyway, it was tough. So you'd push this thing in here and you get it in and get it in so far, and then you'd pick up the spinal needle. The spinal needle also had a stylet in it or an obturator or something inside it that made it so when you looked at the end of the spinal needle, it was solid, but when you pulled this thing out and then you looked at the end of the spinal needle it had a--like a needle that they give you a shot with it, it's got a point on it, comes up like this and--

Herman: An angle. Right, it's beveled.

Wallace: It comes up like this and then it goes that way. A spinal needle would have a real blunt point on it like that, about like that, maybe sixty degrees or so. The reason for that is you don't want a real long exposed end there so where you go into the spinal cord and you think you're in the spinal cord and the point of the needle is halfway out the other side. You know, the spinal cord is only about as big around as a pencil.

So anyway, you would push this thing in there and then you'd push the spinal needle in with your thumbs like this--how would you do it? You'd do like this. Like that. Hey, I'm getting good. Then you'd feel this and you'd push nice and gentle, and you keep pushing, and all of a sudden you feel a little--

Herman: Resistance?

Wallace: --a little pop and it stops. Then you stop and you take this thing out and almost immediately you see this drip, drip.

Herman: Spinal fluid.

Wallace: Cerebral spinal fluid, yeah. So that's good.

Herman: So you'd look for that?

Wallace: Yeah.

Herman: You'd look for the cerebral spinal fluid to come out?

Wallace: Yeah, to come out. Then you've already got your pontocaine and dextrose mixed up and it was about 1 cc--it was equal parts, half pontocaine and half dextrose in water. That was the mixture. It would be about 1.2 to 1.4 cc's of each one. Then you'd put it in there and pull the syringe barrel way back and you'd just mix it up a little bit and you shill air out of the syringe and then you lay that thing down. Once you've mixed it up like that, then you squirt it out to however much you were going to use. It was either 1.2 cc's of each one or when the whole thing was mixed up it was like 1.2 to 1.5 cc's of total fluid. So it's a good thing I'm not anesthetizing anybody right now.

So then when you got the spinal fluid return, then you pick up your syringe and you'd put your hand against the back of the needle and then you'd inject this stuff, take the syringe out, throw it down, pull the thing out, put the cotton ball on his back and then we're going to lay this guy down. Then we'd get him where everything was comfortable and he's moving around, he'd move his arms and shit like that and everything is working good. Then we'd tell him what we were going to do and then after about, I don't know, ten minutes, we'd take a needle, a sterile needle, break the cap off of it. They'd come in cartridges like this and you'd just twist the end of it off and pull the cap off and you still had the hub of the needle in your hand.

So we would tell him, we'd say, "I'm going to touch you on your legs. I'm going to touch you up here. Can you feel this?"

"Yeah, that's sharp."

"Okay, I'm going to touch you down here around your thigh and you tell me when you feel it sharp again."

So you'd go like this and you know it's good down here when you start down here maybe on a belly and you come up this way.

Herman: Up higher and higher toward the waist.

Wallace: You say, "You feel that there?"

He says, "Yeah."

Then you back up a little bit. So good, we got a level, we'll say right about here, that's good, that's acceptable.

Herman: From the navel down, okay.

Wallace: Yeah. We did this one time on a Vietnamese solider. We operated on a lot of Vietnamese people, civilian solders, VC, NVA, it didn't matter. Not too many NVA, but we did. We'd tried to explain to this fellow what we're doing, and I always remember that the Vietnamese people were in this position, in our presence there, way back then I think they all thought that anybody that had anything to do with medicine had a direct line with the Lord, you know. They thought they were very special. They were enlightened people or something like that. And a lot of people probably still feel that way.

So the word that the Vietnamese people used to describe pain, one of them was *dao*, like a Dow pen, but it was probably spelled D-A-O, like *dao*. So we would tell him what we were doing, you know, we'd go, "*Ti ti dao*? Which meant "a little pain."

He'd say, "*Ti ti dao*."

We go down here and we'd go, "*Dao*? *Dao*?" Because I come up this way. "Damn, where's this thing at? *Dao*?" He's not doing anything. So we go like this, "*Dao*?"

"*Dao, dao, dao, dao, dao*!" I remember that happened one time.

There's another story something like that. Well, this was a different type of anesthetic we used to use. Those were spinals, and the hospital corpsmen did that and we did probably most of them on the Vietnamese people.

One of the other things that we did a lot of on the Vietnamese people were skin grafts. The doctors really didn't want to fool with them, and the hospital corpsmen would take an exceptional interest in doing this because it was a neat thing to be able to do. We had the machines called dermatomes, which, I guess, I guess means skin-cutter or something like that.

Herman: It would shave a very thin layer of skin.

Wallace: Yeah, exactly. Yeah. I would say the thickness of the--it seems like the numbers were like ten, eleven, twelve, thirteen, those might have been thousandths of an inch or it may have just been a number. The machine we were using was called a Brown Dermatome and it was driven by a remote motor that hung usually on an IV pole. It had a cable that came down and went right over to the back of this clipper, it looked like a pair of clippers you'd cut sheep with or something. It had a blade housing on it about four inches wide.

So we'd clean up, usually we'd take it from the top of the thigh. The Vietnamese didn't have much hair on them, so this would be cleaned. One guy would run the machine and the other guy would have forceps or tweezers, and as soon as the skin started coming up inside it, he'd just pick it up. You'd just run this thing up here like this and you get the length you want, and then you just lay the handle down, and this thing would cut it right up out of the skin. Then this thing immediately starts to ooze. This was a split thickness skin graft.

So we would put the type of dressing on it that we were using. We used a variety of things, a red-looking stuff, I don't remember what that was called. Adaptive [phonetic] was another one. Xeroform was another one. Then we would wrap this thing up in a big bulky dressing and that was the end of this.

Herman: But then you had the skin.

Wallace: Then we had the skin. Well, at the time we had this thing that was made by an orthopedic company called Zoomer [phonetic], an American company. They make all the hip implants, or they used to, and the hip nails and all that shit and screws.

Well, this thing was kind of like a hand-operated little press that was on a frame about this long and you cranked this thing. It had two rollers that were machined and they were mated to each other and it was like they'd punch holes in this piece of skin. And there was a piece of plastic, it was about three or so inches wide and about ten inches long, and it had a piece of cellophane that was attached to one end. We got to where we'd just tear the cellophane off and not use it. But the idea was to take the skin, get it good and wet, pull the cellophane back and spread the skin out with the backside of the tweezers and get the skin flat and get it stretched out all the way and then lay the cellophane over it. One guy would hold the machine, one guy would crank it, and the third guy would feed this thing into these rollers. It was a hard piece of white plastic about an eighth of an inch thick.

Once the machine picked up on the plastic, it was in there and then you just cranked it and just pulled this thing right through and it'd poke it full of holes. So when you take it out, you

get a sign and you pull the cellophane back, which, like I say, later on we just tore the cellophane off and never used it. You'd pick up this piece of skin that was maybe three inches wide and eight inches long and now it's about twice as big.

The advantage to doing this is you have a piece of skin there that has holes in it, that will still facilitate some draining and usually you didn't graft them until they were pretty well granulated and they were healing up pretty good and you didn't have a lot of drainage. But the biggest advantage of doing it was that you ended up with more skin than what you took from the donor site. These things healed very well. The Vietnamese people were very receptive to--medically they were very receptive to antibiotics, things like this, they did very well with them.

Herman: You say the doctors wouldn't normally do this?

Wallace: No, they wouldn't, they would do something else. They'd be doing a--

Herman: They'd be working on your own people?

Wallace: They'd be taking out a--

Herman: So this was--in other words, if you want to play with these folks--

Wallace: Well, this was time for them, this is what we're going to do. The doctors may be over here doing something else while we're doing a skin graft. A lot of these skin grafts would have probably been done during dressing changes in the morning, like I said.

Herman: Oh, you just had time to do them right then?

Wallace: Yeah. Yeah, we weren't just experimenting on--well, I don't think that would be the way to describe it. But these people got pretty good care from us, and all the hospital corpsman I worked with were conscientious and they were very good at what they did. That's the way I would describe all of them.

Herman: Okay. Well, we're out of tape.

[End of interview]